IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

December 31, 2007

Patrick Hermanson
Portneuf Medical Center
651 Memorial Drive
Pocatello, Idaho 83201-4701

Provider #130028

Dear Mr. Hermanson:

On **November 2, 2007**, a Complaint Investigation was conducted at Portneuf Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003223

Allegation #1: A patient received poor basic nursing care. Attends were not changed in a timely manner. One patient had skin breakdown on thighs, buttocks, heels, and groin. The patient was not kept clean, was not showered or shaved and had dried food on his mouth.

Findings: An unannounced visit was made to the hospital on November 1 and 2, 2007. Staff and patients were interviewed. Eight medical records were reviewed. Hospital policies were reviewed.

Fourteen patients and/or their families were interviewed on the morning of 11/1/07. All of the persons interviewed stated the care was very good. They said the hospital had plenty of staff and responded quickly to call lights. They stated staff assisted patients to turn when needed and provided personal cares when needed. All patients were observed to be clean and well groomed. Two Registered Nurses (RNs) were interviewed. Both stated the hospital was sufficiently staffed and they felt they had enough time and resources to provide personal care to patients.

Photographs of one patient, upon the arrival of his transfer to another local hospital, were reviewed. The photographs showed he was not shaved and had crusted food on his mouth and face. The photographs also showed red lines on his buttocks and thighs from his attends. This patient's record was chosen for review along with 7 others. The patient was a 67 year old male who was admitted on 8/21/07 and discharged on 8/27/07. Diagnoses included altered mental status, abnormal movement disorder, and schizoaffective disorder. The patient required assistance with all activities of daily living. While at times the documentation was sporadic, especially in computerized notes where cares were chosen from an on-screen menu, daily notes were present which documented assistance was provided with feeding, bathing, peri care, changing linens and attends when needed. The patient was frequently incontinent and documentation was present he was provided care when this occurred. No skin breakdown was documented except for an abrasion on the patient's heel which the patient stated was an old injury. The patient's skin was documented as "intact" through 8 AM on 8/27/07. No personal cares were documented after 8 AM on 8/27/07. Only one nursing note was present after 8 AM. It stated "pt had been sleeping, still answers one word answers. still unable to get pt to drink. Dr (name) here to write discharge orders. The patient was discharged at approximately 4 PM. A discharge note was not present in the record. Except for the above nursing note, no nursing notes described the patient's condition or care after 8 AM on 8/27/07. Assistance with activities of daily living and personal cares was documented in the remaining 7 records.

The RN who cared for the above patient was interviewed on 11/1/07 at 3:54 PM. She stated she remembered giving the patient a bed bath on 8/27/07 but could not remember what other cares were provided. She stated she always provides oral care to her patients. She could not explain why the patient did not have a discharge note. She said she thought the patient was sitting up in a wheel chair early in the afternoon waiting for discharge. She thought the patient was discharged without her specific knowledge. She did not think the aide had summoned her when people came to transfer the patient. She said the normal procedure was to obtain a set of discharge vital signs, examine the patient, and write a final nursing note but this did not happen.

The complaint was substantiated. Photographs showed the patient was dirty and disheveled upon arrival at the receiving hospital. No documentation of care was present for approximately 8 hours of the patient's final day of admission. The lack of care to this patient appeared to be an aberration, however. From interviews and other documentation, it appeared care was being provided to patients. No deficiencies were cited. A serious deficiency was cited in relation to discharge planning. This will require a full survey of the hospital. Nursing care will be reviewed again at that time.

Conclusion #1: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: A patient was transferred from the hospital to a lower level of care. The patient was not stable.

Findings: Eight medical records were reviewed. Two of those patients were transferred to other hospitals. One patient was a 67 year old male who was admitted on 8/21/07 and transferred on 8/27/07. His diagnoses included altered mental status, abnormal movement disorder, and schizoaffective disorder. His discharge summary, dictated on 8/27/07, stated "The patient was admitted to the medicine floor to manage his altered mental status and his abnormal movements along with his pain. He had a fairly unremarkable hospital course. For a short time it did seem that his tremors did increase and it was considered that this may be an alcohol withdrawal and this was treated with his benzodiazepines. His altered mental status did continue to improve. He did have a notable white count and a location for an infection was never found although we did do a urinalysis, chest x-ray, and found no source of infection. This was likely a secondary response to the stress of possible DTs or possible viral infection." The patient was transferred to a geriatric psychiatric hospital on 8/27/07. This hospital had very limited capabilities to treat medical conditions.

Nursing notes stated the patient was alert and restless on admission. He had involuntary movements described as "extrapyramidal". On 8/27/07, nurses began charting that his level of consciousness was decreasing. At 8 AM, a nursing note stated he was "somnolent. vitals taken by auscultation and dinamap bp is low. Dr. (name) aware. pt will not open eyes to command. body is limp. pt did mutter 'thirsty'. attempted to give pt drink but he is unable to suck through the straw and tipping the fluid causes coughing. used wet washcloth to try to awaken pt. pt still somnolent. Dr (name) assessed and stated I may hold am meds for now." At 1:39 PM, the nurse documented "pt has been sleeping. still answers one word answers. still unable to get pt to drink. have spoke with (name) from (geriatric psychiatric hospital). No further nursing notes were present in the record. A physician's note at 8 AM stated the patient was difficult to arouse and had spiked a temperature of 100.4 the previous evening. (The patient was afebrile at 9:05 AM and 3:33 PM on 8/27/07.) Another MD note stated the patient was quite sedated, likely from the Seroquel he was receiving. A neurologist examined the patient at 11:30 AM and stated the patient was sedated due to medications.

The RN who cared for the above patient was interviewed on 11/1/07 at 3:54 PM. She stated she lost track of the patient on the afternoon he was discharged. She said she thought the patient was sitting up in a wheel chair early in the afternoon waiting for discharge. She said she thought the patient was discharged without her specific knowledge. She did not think the aide had summoned her when people came to transfer the patient. She said the normal procedure was to obtain a set of discharge vital signs, examine the patient, and write a final nursing note but this did not happen. She was unable to state what the patient's condition and level of consciousness were

According to a progress note at the receiving hospital, dated 8/27/07 at 4 PM, the patient's temperature was 101.9 when he arrived. His blood pressure was 97/57, pulse was 77, respirations were 24, and his oxygen saturation level was low at 82% on room air. Oxygen was started and the patient was transferred back to the emergency department at Portneuf Medical Center where he arrived at 5:15 PM. He was diagnosed with pneumonia and readmitted as an inpatient where he stayed until his discharge on 9/3/07.

As with the first allegation, there was a breakdown in communication with the nursing staff prior to and at the time of discharge. While the other patients', whose cases were reviewed, did not return to the hospital, it was determined the hospital had not developed a specific discharge planning process. Deficiencies were cited at 42 CFR, Part 482.43 Condition of Participation for Discharge Planning.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Trish O'Hara for

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

November 27, 2007

Patrick M. Hermanson, CEO
Portneuf Medical Center
651 Memorial Drive
Pocatello, ID 83201

CMS Certification Number: 13-0028

Dear Mr. Hermanson:

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The Idaho Bureau of Facility Standards (State agency) completed a complaint investigation authorized by the Centers for Medicare and Medicaid Services (CMS) on November 2, 2007. Based on a review of the deficiencies identified during this investigation, we have determined that Portneuf Medical Center **is not in substantial compliance with the Medicare hospital Condition of Participation – Discharge Planning (42 C. F. R. § 482.43).**

Section 1865 of the Social Security Act (The Act) and pursuant regulations provide that a hospital accredited by The Joint Commission will be "deemed" to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of the Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency which would, if found to be present, adversely affect the health and safety of patients. If, in the course of such a survey, a hospital is found to have significant deficiencies with respect to compliance with the Conditions of Participation, we are required, following timely notification of the accrediting body, to place the hospital under Medicare State Agency survey jurisdiction until the hospital is in compliance with all Conditions of Participation.

The deficiencies cited limit the capacity of Portneuf Medical Center to furnish services of an adequate level or quality. The deficiencies, which led to our decision, are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

Portneuf Medical Center must submit a plan of correction to our office for all deficiencies cited on the November 2, 2007, CMS-2567, Statement of Deficiencies. The plan of correction must be submitted to our office within ten (10) days of receipt of this letter.

Complete your Plans of Correction in the space provided on the CMS-2567s, and return a copy to each of the addresses shown below. **An acceptable plan of correction, which includes acceptable completion dates, must contain the following elements:**

- The plan of correcting the specific deficiency and how the hospital will act to protect other patients in a similar situation;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- Dates when the plan of correction will be completed;
- The title of the person responsible for implementing the acceptable plan of correction.

Each deficiency should be corrected as soon as possible, but no later than December 31, 2007. Additionally, you must sign and date page one where indicated prior to returning the Forms 2567 to our office.

Please send the completed plan of correction no later than December 12, 2007, to the addresses below:

CMS – Survey and Certification
Attention: Jerilyn McClain
2201 Sixth Avenue, RX-48
Suite 645
Seattle, WA 98121
Fax: (206) 615-2088

Idaho Bureau of Facility Standards
Attention: Sylvia Creswell
P.O. Box 83720
Boise, Idaho 83720-0036
Fax: (208) 364-1888

Additionally, in accordance with § 1865(b) of the Social Security Act, the Idaho Bureau of Facility Standards, will conduct a full survey of your hospital to assess compliance with all the Medicare Conditions of Participation, within the next 60 days.

The requirement that Portneuf Medical Center submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When Portneuf Medical Center's plan of correction has been approved and implemented, and then found to meet all the Medicare Conditions of Participation for hospitals, the State agency will discontinue its survey jurisdiction.

Under CMS regulations 42 C. F. R. § 498.3, this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Copies of this letter are being provided to the State Survey Agency and The Joint Commission. You can also pursue any concerns you may have with the Joint Commission at any time.

If you have any questions, please contact Jerilyn McClain of my staff at (206) 615-2313.

Sincerely,

for

Steven Chickering
Western Consortium Survey and Certification
Division of Survey and Certification

Enclosure

cc: Debby Ransom, Bureau of Facility Standards
The Joint Commission

Portneuf
MEDICAL CENTER

651 Memorial Dr., Pocatello, Idaho 83201
Phone: (208) 239-1000

December 6, 2007

RECEIVED
DEC 10 2007
FACILITY STANDARDS

Sylvia Creswell
Idaho Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

Dear Ms. Creswell:

We appreciate the thorough review and guidance provided to Portneuf Medical Center by Mr. Gary Guiles and Ms. Patricia O'Hara on November 2, 2007 in regard to our level of compliance with the discharge planning practices required in the Medicare Conditions of Participation (42 C.F.R. § 482.43). We immediately addressed the issues cited and we have delineated our corrective changes in the enclosed Plan of Correction form as directed. This form is being mailed to the parties specified in Steven Chickering's letter dated November 27, 2007.

We have also completed the necessary staff education to maintain these changes. We believe that Portneuf Medical Center is now in compliance with the Medicare Hospital Conditions of Participation regarding Discharge Planning.

Thank you for working with Portneuf Medical Center to accomplish this improvement in our care processes.

Sincerely,

Patrick M. Hermanson

Pat Hermanson
President & CEO

PH/hg

Enclosures

cc: Steven Chickering, Western Consortium Survey & Certification
Gary Hart, M.D., Vice President Medical Affairs

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/26/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130028	A. BUILDING _____ B. WING _____	C 11/02/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF MEDICAL CENTER	651 MEMORIAL DRIVE POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Patricia O'Hara, RN, HFS Acronyms used in the survey report include: ADL = Activity of Daily Living CM = Case Manager DME = Durable Medical Equipment EMR = Electronic Medical Record SNF = Skilled Nursing Facility SWS = Social Work Services VA = Veterans Administration	A 000	RECEIVED DEC 11 2007 FACILITY STANDARDS	
A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on review of hospital policies and quality improvement records, clinical record review, and staff interview, it was determined the hospital failed to develop and implement an effective discharge planning process. The hospital failed to identify patients at an early stage of	A 799	The hospital has in effect a discharge planning process that applies to all patients admitted to the acute care setting. - See Attachment A (Policy & Procedure) - See Attachment B (PMC Discharge Planning Process) Director of Case Management designee to monitor for compliance.	Dec. 31, 2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Melissa R Cowles RN Interim VP Pt Care Services 12-11-07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on review of hospital policies and quality improvement records, clinical record review, and staff interview, it was determined the hospital failed to develop and implement an effective discharge planning process. The hospital failed to identify patients at an early stage of	A 799	The hospital has in effect a discharge planning process that applies to all patients admitted to the acute care setting. - See Attachment A (Policy & Procedure) - See Attachment B (PMC Discharge Planning Process) Director of Case Management designee to monitor for compliance.	Dec. 31, 2007

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A 799	Continued From page 1 hospitalization, who were likely to suffer adverse health consequences upon discharge, if there was not adequate discharge planning (A800). The hospital failed to develop and provide discharge planning evaluations (A806). The hospital failed to develop and implement discharge plans (A818). The hospital failed to reassess its discharge planning process on an on-going basis, including a review of discharge plans, to ensure that they were responsive to discharge needs (A843). The cumulative effect of these systemic practices resulted in the hospital's inability to ensure the patients' post acute care needs were met.	A 799		
A 800	482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by: Based on review of hospital policies and clinical records and staff interview, it was determined the hospital failed to identify patients, at an early stage of hospitalization, who were likely to suffer adverse health consequences upon discharge if there was not adequate discharge planning. This was the case for 7 of 7 patients (#'s 1, 2, 3, 4, 5, 6, and 8) for whom discharge planning was	A 800	The hospital identifies at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. Referrals will be made to case management through written physician orders, clinical system referrals, or verbally. Case Manager/Social Worker will also identify potential needs by utilizing, but not limited to, "Screening Criteria for Discharge Planning", review of daily census, patient's medical record, patient/family interaction, and interdisciplinary rounds. - continued -	Dec. 31, 2007

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A 800	Continued From page 2 reviewed. The findings include: 1. The policy "Patient Consultation & Referral to Social Work Services", updated 8/01, stated "High risk patients and their families will be identified and provided referral to appropriate services." The policy further stated, "4.1. Patients identified as high risk receive initial screening by Social Work Services." The policy did not define "high risk patients" and did not specifically refer to discharge planning. The policy did include a list of patients to be referred to SWS but the list was very broad. It included 58 categories of both inpatients and outpatients in categories as diverse as patients with cardiac arrest, babies born with birth defects, uninsured patients, children with fractures, and single parents. It was not clear, from language in the policy, that referrals to SWS would result in discharge planning services. CMs were responsible for discharge planning at the hospital. Staff A was a CM who was interviewed on 11/2/07 at 8:40 AM. She stated the EMR automatically emailed CMs of social service needs but she did not think this was documented in patients' records. She said that those emails just triggered a SWS referral but did not necessarily trigger discharge planning services. For example, she stated SWS could be notified if a box was checked stating the patient did not have a living will or had other social service needs. She stated there was no specific process to identify patients with potential discharge planning needs. 2. Assessments to identify patients with potential discharge planning needs at an early stage of hospitalization were not documented for 7 of 7	A 800	Documentation of decision to initiate discharge planning, or not, will be placed in the medical record. - See Attachment C (Screening Criteria) Director of Case Management/designee to monitor for compliance.	Dec. 31, 2007

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A 800	Continued From page 3 patients (#'s 1, 2, 3, 4, 5, 6, and 8). Examples include: * Patient #1 was a 60 year old male who spoke limited English. He was admitted to the hospital in respiratory failure secondary to pneumonia on 8/28/07. He was maintained on a ventilator until 9/1/07 and recovered sufficiently to be discharged home on 9/10/07. At discharge, he required a hospital bed, continuous oxygen, and Bi-level Positive Airway Pressure. An assessment of potential discharge planning needs was not present in the record. The first CM note was dated 8/29/07 at 9:45 AM. It stated "Per patient's daughter (name); Patient does speak and understand English, he has been living at home with his wife, just started using home oxygen but not sure of DME provider. Patient had been working full time up until Jan 2007 but has been on short term disability since then." An assessement to determine if she was likely to suffer adverse health consequences upon discharge if there was not adequate discharge planning, was not documented. This was confirmed by Staff A who was interviewed on 11/2/07 at 8:40 AM. * Patient #2 was a 67 year old male who was admitted to the hospital with a diagnosis of altered mental status, abnormal movement disorder, and schizoaffective disorder on 8/21/07. He was discharged on 8/27/07. The physician Discharge Summary, dated 8/27/07, stated the patient was being discharged to a skilled nursing facility. However, the patient was actually discharged to a geriatric psychiatric hospital. An assessment to determine if the patient was likely to suffer adverse health consequences upon discharge if there was not adequate discharge	A 800		

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A 800	Continued From page 4 planning was not present in the record. This was confirmed by Staff A on 11/2/07 at 8:40 AM. * Patient #4 was an 18 year old female who was admitted to the hospital with diagnoses of pneumonia, anemia, and Down's Syndrome, on 8/9/07. She was discharged home on 8/13/07. An assessment to determine if the patient was likely to suffer adverse health consequences upon discharge if there was not adequate discharge planning was not present in the record. This was confirmed by Staff A on 11/2/07 at 11:05 AM. * Patient #6 was a 39 year old female who was admitted to the hospital with a diagnosis of herpes simplex encephalitis on 9/6/07. She was discharged home on 9/13/07. An assessment to determine if the patient was likely to suffer adverse health consequences upon discharge if there was not adequate discharge planning was not present in the record. This was confirmed by Staff A on 11/2/07 at 11:05 AM. * Patient #8 was an 89 year old female admitted on 8/19/07 with the diagnoses of bronchitis and CHF. She also had comorbid diagnoses of breast cancer with metastasis to the lungs and mild dementia. An assessment to determine if the patient was likely to suffer adverse health consequences upon discharge if there was not adequate discharge planning was not present in the record. The single CM note, on 8/20 stated, "Pt. may benefit from home health services upon d/c." Staff A confirmed on 11/2 at 1:30 P.M. that no assessment of the need for a discharge planning evaluation was documented.	A 800		

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A 800	Continued From page 5 * Patient #3 was a 62 year old male admitted on 9/6/07. Admitting diagnoses were increasing cough, shortness of breath and rule out tuberculosis. He had a comorbid diagnosis of renal failure. He was admitted from an extended care facility where he was recovering from bowel surgery. The extended care facility did not have a bed available for the patient at the time of his discharge. He was discharged on 9/13/07 to the home of his adult son. The son worked during the day but was willing to take the patient to his dialysis appointments three times a week. Home Health was to open the patient the next day. No assessment of the need for a discharge planning evaluation was documented. This was confirmed by Staff A on 11/2 at 1:40 P.M. * Patient #5 was a 58 year old male admitted on 8/7/07. Admitting diagnoses were pneumonia and COPD exacerbation. He was discharged on 8/10 to a V.A. hospital. The history and physical, dated 8/3/07, stated he had " known severe COPD who is on home O2 and 10mg. Prednisone scheduled". He also had a history of Pancreatitis. He also utilized Bi-level Positive Airway Pressure. He had been admitted on 8/3/07 with the same diagnosis and discharged on 8/4/07 with instructions to follow up with the V.A. hospital. An assessment to determine if the patient was likely to suffer adverse health consequences upon discharge if there was not adequate discharge planning was not present in either record. There were no Case Manager notes in the EMR. This was confirmed by Staff A, who was the CM who saw Patient #5.	A 800		
A 806	482.43(b)(1) DISCHARGE PLANNING NEEDS ASSESSMENT	A 806		

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A 806	Continued From page 6 The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. This STANDARD is not met as evidenced by: Based on review of hospital policies, record review and staff interview it was determined the hospital failed to develop and provide a discharge planning evaluation for 7 of 7 sampled patients (#'s 1, 2, 3, 4, 5, 6, and 8) for whom discharge planning was reviewed. The findings included: 1. The Director of Case Management and Social Services was interviewed on 11/2/07 at 11:55 AM. She was asked for copies of policies outlining the discharge planning process and defining discharge planning evaluations. She provided 2 policies-"SOCIAL WORK GENERAL DOCUMENTATION GUIDELINES" and "Patient Consultation & referral to Social Work Services", dated 11/05 and 8/01, respectively. These policies did not specifically address discharge planning. She stated no policies addressing the discharge planning process and defining discharge planning evaluations had been developed by the hospital. 2. Seven of seven sampled patients (#'s 1, 2, 3, 4, 5, 6, and 8), who needed additional medical services upon discharge, did not have discharge	A 806	The hospital does provide a discharge planning evaluation to patients identified as being at risk for negative outcome if discharge planning is not done. The Case Manager/Social Worker will be responsible for the discharge planning evaluation using input from the patient, or individual acting on behalf of the patient, the interdisciplinary care team, the physician, and information in the medical record. The assessment and plan will be updated/revised as needed and will be documented. A copy will be placed in the patient's medical record. The frequency of assessment depends on the patient's condition, anticipated length of stay and response to medical care. Patients will be re-evaluated prior to discharge to ensure plans are still appropriate and in place. A discharge summary will be placed in the medical record at time of discharge. - continued -	Dec. 31, 2007

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A 806	Continued From page 7 planning evaluations. Examples include: * Patient #1 was a 60 year old male who spoke limited English. He was admitted in respiratory failure secondary to pneumonia on 8/28/07. He was maintained on a ventilator until 9/1/07 and recovered sufficiently to be discharged to home on 9/10/07. At discharge, he required a hospital bed, continuous oxygen, and Bi-level Positive Airway Pressure. A discharge planning evaluation was not present in the record. Two case management notes were documented. The first CM note was dated 8/29/07 at 9:45 AM. It stated "Per patient's daughter (name); Patient does speak and understand English, he has been living at home with his wife, just started using home oxygen but not sure of DME provider. Patient had been working full time up until Jan 2007 but has been on short term disability since then." The second note was dated 9/7/07 at 9:45 AM. It stated the patient lived with his wife, had been independent in ADLs and able to drive prior to admission. The note stated he had "additional family support" from his daughter but did not explain that. It stated he had no home care services and named the company that provided oxygen. The note stated "He will discharge back to his home setting pending status and MD orders. SW/CM to follow as needed." No specific evaluation of discharge planning needs was documented. This was confirmed by Staff A who was interviewed on 11/2/07 at 8:40 AM. Staff A was a CM but was not the CM for Patient #1. * Patient #2 was a 67 year old male who was admitted to the hospital with a diagnosis of altered mental status, abnormal movement disorder, and schizoaffective disorder on 8/21/07.	A 806	Director of Case Management/designee to monitor for compliance.	Dec. 31, 2007

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A 806	Continued From page 8 He was discharged on 8/27/07. The physician Discharge Summary, dated 8/27/07, stated the patient was being discharged to a skilled nursing facility. However, the patient was actually discharged to a geriatric psychiatric hospital. A CM note, dated 8/22/07 at 11 AM, stated "Tentative Disposition: (Geriatric) Psych Hospital." The next CM note was dated 8/24/07 at 3:53 PM. It stated "(Facility) will only take after neurologist assesses patient, (name) MD aware, recent vomiting and elevated wbc". The final note, on 8/27/07 at 3:30 PM, stated "d/c to (name) psych today." A discharge planning evaluation was not present in the record. This was confirmed by Staff A, the CM for Patient #2, on 11/2/07 at 8:40 AM. * Patient #4 was an 18 year old female who was admitted to the hospital with diagnoses of pneumonia, anemia, and Down's Syndrome on 8/9/07. She was discharged home with her parents on 8/13/07. According to the history and physical, dated 8/9/07, she had also been hospitalized on 7/9-12/07 for pneumonia. At that time she had been discharged home on continuous oxygen. The report stated she did not fully recover and again her condition deterriorated. At the time of the 8/9 admission, she was anemic with a hemoglobin of 9.2 and also had a low albumin level of 2.0, indicating dietary problems. These laboratory levels had declined from her July admission. A discharge planning evaluation was not present in the record. No CM notes were in the record. This was confirmed by Staff A on 11/2/07 at 11:05 AM. * Patient #6 was a 39 year old female who was admitted to the hospital with a diagnosis of herpes simplex encephalitis on 9/6/07. She was	A 806		

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A 806	Continued From page 9 discharged home on 9/13/07. A CM note on 9/12/07 at 11 AM stated "may consider home health in the next few days." A CM note, dated 9/2/07 at 3:32 PM, stated the patient "Was alerted to the possibility of home vs outpatient IV antibiotics. Infusion therapy will not accept TID medications...Patient may be able to do home health for infusion therapy..." No other CM notes were present in the record. A discharge planning evaluation was not present in the record. An evaluation of the need for assistance with infusion therapy was not present in the record. This was confirmed by Staff A on 11/2/07 at 11:05 AM. Staff A was a CM but was not the CM for Patient #1. * Patient #8 was an 89 year old female who was admitted on 8/19/07. Admitting diagnoses were bronchitis and CHF. She also had comorbid diagnoses of metastatic breast cancer to the lungs, COPD and mild dementia. She was discharged on 8/24/07 to home on oxygen therapy. A CM note, dated 8/20/07 at 9:30 A.M., stated, "Pt lives with her son. Pt. should d/c to home with Home Health vs. family assist in 3-4 days." Another CM note, dated 8/20/07 at 10:39 A.M., stated the patient had been living in another state and had recently moved here to live with her son. "Patient also has metastatic breast CA. Pt. denies any recent use of DME, oxygen, or Home Health services. Pt. may benefit from Home Health services upon d/c. CM will assist as needed and as ordered with this pt." There was no documentation in her medical record showing that a discharge planning evaluation had been done. On 11/2/07 at 11:40 A.M. the Case Manager stated that there were "no set, every case guidelines" used to identify patients with discharge planning needs. She confirmed that a	A 806		

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A 806	Continued From page 10 comprehensive discharge planning evaluation was not present for Patient #8. * Patient #5 was a 58 year old male admitted on 8/7/07. Admitting diagnoses were pneumonia and COPD exacerbation. He was discharged on 8/10 to a V.A. hospital. The history and physical, dated 8/3/07, stated he had " known severe COPD who is on home O2 and 10mg. Prednisone scheduled". He also had a history of Pancreatitis. He also utilized Bi-level Positive Airway Pressure. He had been admitted on 8/3/07 with the same diagnosis and discharged on 8/4/07 with instructions to follow up with the V.A. hospital. There was no documentation in either of his medical records that a discharge planning evaluation had been done. There were no Case Manager notes in the EMR. This was confirmed by Staff A, the patient's CM, on 11/2 at 1:40 P.M. * Patient #3 was a 62 year old male admitted on 9/6/07 from a local skilled nursing facility where he was recovering from colon surgery. His admitting diagnosis was cough, shortness of breath and rule out Tuberculosis. He had the comorbid diagnosis of renal failure and was dialysis dependent. He was discharged on 9/13/07 to his son's home. He spoke limited English. The first CM note regarding discharge planning was dated 9/12/07 at 2:35 P.M. It stated the CM spoke with the patient and his plan was to go home with his adult sons. The note also stated the patient appeared confused. The next CM note was dated 9/12/07 at 2:49 P.M. The note stated she had called the skilled nursing facility and "they state (Patient #3) was a resident there prior to PMC admission. Family working during day and unable to reach at this time. CM	A 806		

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A 806	Continued From page 11 to assist with placement when orders written." The note did not state whether or not bed availability was discussed. There was no documentation in his medical record that a discharge planning evaluation had been done. The patient was ultimately discharged to home because there was no bed available at the skilled nursing facility. This was confirmed by Staff A, who was the patient's CM, on 11/2/07 at 11:40 A.M.	A 806		
A 818	482.43(c)(1) QUALIFIED PERSONNEL A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan. This STANDARD is not met as evidenced by: Based on review of hospital policies and clinical records and staff interview, it was determined hospital staff failed to develop and implement discharge plans for 7 of 7 sampled patients (#'s 1, 2, 3, 4, 5, 6, and 8) with discharge planning needs. The findings included: 1. The Director of Case Management and Social Services was interviewed on 11/2/07 at 11:55 AM. She was asked for copies of policies outlining the discharge planning process and defining discharge planning evaluations. She provided 2 policies-"SOCIAL WORK GENERAL DOCUMENTATION GUIDELINES" and "Patient	A 818	Case Managers are given the responsibility to assess every patient for discharge planning needs to execute the appropriate and ordered discharge plan. Case Managers may be registered nurses or social workers. Case Management staff will be educated on the Discharge Planning process. - See Attachment D (Job Descriptions) - See Attachment E (Education Record) Director of Case Management/designee to monitor compliance.	Dec. 31, 2007

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A 818	Continued From page 12 Consultation & referral to Social Work Services", dated 11/05 and 8/01, respectively. These policies did not specifically address discharge planning. She stated no policies addressing the discharge planning process and defining discharge plans had been developed by the hospital. 2. Seven of seven sampled patients (#'s 1, 2, 3, 4, 5, 6, and 8), who needed additional medical services upon discharge, did not have specific discharge plans. Examples include: * Patient #1 was a 60 year old male who spoke limited English. He was admitted in respiratory failure secondary to pneumonia on 8/28/07. He was maintained on a ventilator until 9/1/07 and recovered sufficiently to be discharged to home on 9/10/07. At discharge, he required a hospital bed, continuous oxygen, and Bi-level Positive Airway Pressure. A discharge planing evaluation was not present in the record. Two case management notes were documented. The first CM note was dated 8/29/07 at 9:45 AM. It stated "Per patient's daughter (name); Patient does speak and understand English, he has been living at home with his wife, just started using home oxygen but not sure of DME provider. Patient had been working full time up until Jan 2007 but has been on short term disability since then." The second note was dated 9/7/07 at 9:45 AM. It stated the patient lived with his wife, had been independent in ADLs and able to drive prior to admission. The note stated he had "additional family support" from his daughter but did not explain that. It stated he had no home care services and named the company that provided oxygen. The note stated "He will discharge back to his home setting pending status and MD	A 818		

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A 818	Continued From page 13 orders. SW/CM to follow as needed." No specific discharge plan was documented. No documentation was present stating whether or not home health services had been pursued. No documentation was present confirming that the needed DME had been delivered and awaited the patient upon discharge. This was confirmed by Staff A who was interviewed on 11/2/07 at 8:40 AM. * Patient #2 was a 67 year old male who was admitted to the hospital with a diagnosis of altered mental status, abnormal movement disorder, and schizoaffective disorder on 8/21/07. He was discharged on 8/27/07. The physician Discharge Summary, dated 8/27/07, stated the patient was being discharged to a SNF. However, the patient was actually discharged to a geriatric psychiatric hospital. The "Medical Floor Discharge Checklist", dated 8/22/07 but not timed, stated report was called to a SNF. A CM note, dated 8/22/07 at 11 AM, stated "Tentative Disposition: (Geriatric) Psych Hospital." The next CM note was dated 8/24/07 at 3:53 PM. It stated "(Facility name-the note did not specify a hospital or SNF) will only take after neurologist assesses patient, (name) MD aware, recent vomiting and elevated wbc". The final note, on 8/27/07 at 3:30 PM, stated "d/c to (name) psych today. A discharge plan was not present in the record. This was confirmed by Staff A on 11/2/07 at 8:40 AM. According to a second medical record, Patient #2 was discharged to a psychiatric hospital on 8/27/07, but he returned to Portneuf Medical Center 2 hours after discharge. The History and Physical, dated 8/27/07, stated his temperature was 101.9 and his blood pressure was 81/55 at	A 818		

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A 818	Continued From page 14 admission. He was "hypoxic with oxygen saturations in the 82% range." He was readmitted to the medical floor as an inpatient for "a hospital acquired pneumonia". * Patient #4 was an 18 year old female who was admitted to the hospital with diagnoses of pneumonia, anemia, and Down's Syndrome on 8/9/07. She was discharged home with her parents on 8/13/07. According to the history and physical, dated 8/9/07, she had also been hospitalized on 7/9-12/07 for pneumonia. At that time she had been discharged home on continuous oxygen. The report stated she did not fully recover and again her condition deteriorated. At the time of the 8/9 admission, she was anemic with a hemoglobin of 9.2 and also had a low albumin level of 2.0, indicating dietary problems. These laboratory levels had declined from her July admission. A discharge plan was not present in the record. No other CM notes were in the record. This was confirmed by Staff A on 11/2/07 at 11:05 AM. * Patient #6 was a 39 year old female who was admitted to the hospital with a diagnosis of herpes simplex encephalitis on 9/6/07. She was discharged home on 9/13/07. A CM note on 9/12/07 at 11 AM stated "may consider home health in the next few days." A CM note, dated 9/2/07 at 3:32 PM, stated The patient "Was alerted to the possibility of home vs outpatient iv antibiotics. Infusion therapy will not accept TID medications...Patient may be able to do home health for infusion therapy..." Discharge Instructions, dated 9/13/07 but not timed, stated the patient was discharged with "Acyclovir 640 oral every 8 hours" in typeface and "by home health" was printed under this. The Discharge	A 818		

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A 818	Continued From page 15 Instructions also stated "6. Special Instructions: ...Administer Acyclovir IV". The clinical record did not state whether a home health agency had agreed to accept the patient or not. A discharge plan was not present in the record. This was confirmed by Staff A on 11/2/07 at 11:05 AM. * Patient #3 was a 62 year old male admitted on 9/6/07 from a local skilled nursing facility where he was recovering from colon surgery. His admitting diagnosis was cough, shortness of breath and rule out Tuberculosis. He had the comorbid diagnosis of renal failure and was dialysis dependent. He was discharged on 9/13/07 to his son's home. He spoke limited English. The first CM note regarding discharge planning was dated 9/12/07 at 2:35 P.M. It stated the CM spoke with the patient and his plan was to go home with his adult sons. The note also stated the patient appeared confused. The next CM note was dated 9/12/07 at 2:49 P.M. The note stated she had called the skilled nursing facility and "they state (patient #3) was a resident there prior to PMC admission. Family working during day and unable to reach at this time. CM to assist with placement when orders written." The note did not state whether or not bed availability was discussed. The CM note on 9/13/07 at 3:43 P.M. stated "no availability at (skilled nursing facility. Physician) aware and ordered home care. Son... states he is willing to take patient to dialysis." One Home Health Agency refused to accept the patient but a second Home Health Agency accepted him. No assessment of the home environment was documented. The patient was confused. The above CM note on 9/12/07 stated that the family worked during the day. It was not documented what kind of supervision the patient would have at	A 818		

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A 818	Continued From page 16 home. There was no discharge plan in the record. This was confirmed by Staff A on 11/2 at 11:05 A.M. * Patient #5 was a 58 year old male admitted on 8/7/07. Admitting diagnoses were pneumonia and COPD exacerbation. He was discharged on 8/10 to a V.A. hospital. The history and physical, dated 8/3/07, stated he had " known severe COPD who is on home O2 and 10mg. Prednisone scheduled". He also had a history of Pancreatitis. He also utilized Bi level Positive Airway Pressure. He had been admitted on 8/3/07 with the same diagnosis and discharged on 8/4/07 with instructions to follow up with the V.A. hospital. There was no discharge planning evaluation documented. There were no Case Manager notes in the EMR. No discharge plan was documented. This was confirmed by Staff A on 11/2 at 1:40 P.M. * Patient #8 was an 89 year old female who was admitted on 8/19/07. Admitting diagnoses were bronchitis and CHF. She also had comorbid diagnoses of metastatic breast cancer to the lungs, COPD and mild dementia. She was discharged on 8/24/07 to home on oxygen therapy. A CM note, dated 8/20/07 at 9:30 A.M., stated "Pt lives with her son. Pt. should d/c to home with Home Health vs. family assist in 3-4 days." Ano ther CM note, dated 8/20/07 at 10:39 A.M., stated the patient had been living in another state and had recently moved here to live with her son. "Patient also has metastatic breast CA. Pt. denies any recent use of DME, oxygen, or Home Health services. Pt. may benefit from Home Health services upon d/c. CM will assist as needed and as ordered with this pt." There was no documentation in her medical record showing	A 818		

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A 818	Continued From page 17 that a discharge planning evaluation had been done. No other CM notes were present in the record. A Patient Rounding Note, dated 8/24/07 at 10:30 A.M., stated the DME company was "here with oxygen set -up. Family instructed. Discharge instructions discussed with son-written instructions given." She was discharged to her son's home. There was no discharge plan present in her medical record. There was no documentation whether or not the patient needed Home Health services. This was confirmed by Staff A on 11/2 at 11:05 A.M.	A 818		
A 843	482.43(e) REASSESSMENT OF DISCHARGE PLANNING PROCESS The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs. This STANDARD is not met as evidenced by: Based on review of hospital policies and quality improvement documents and staff interview, it was determined the hospital failed to reassess its discharge planning process on an on-going basis, including a review of discharge plans to ensure that they were responsive to discharge needs. The findings include: 1. A program to assess the quality of the hospital's discharge planning process had not been developed or implemented. No process	A 843	The hospital does reassess its discharge planning process on an on-going basis. Review of discharge plans (random audits) will be undertaken quarterly to ensure that they are responsive to discharge needs. This review will include: 1. Timeliness of the use of criteria to identify patients needing discharge planning. 2. The quality and timeliness of discharge planning evaluations and discharge plans. 3. Documentation that available options were presented to the patient for post hospital needs. - continued -	Dec. 31, 2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130028	A. BUILDING _____ B. WING _____	C 11/02/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF MEDICAL CENTER	651 MEMORIAL DRIVE POCATELLO, ID 83201

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A 843	Continued From page 18 was in place to evaluate the following: * Timeliness of the criteria to identify patients needing discharge plans; * The quality and timeliness for discharge planning evaluations and discharge plans; * Whether or not hospital discharge personnel maintained complete and accurate information to advise patients and their representatives of appropriate options. In addition, the hospital failed to identify the lack of a system to provide discharge planning screens, discharge planning evaluations, and discharge plans to patients. The Director of Quality Management was interviewed on 11/2/07 at 11:55 AM. She stated the hospital was monitoring 2 indicators which included the "% of charts with evidence of interdisciplinary goal setting" and "% of interdisciplinary team discharge disposition (divided by) total # of acute care discharged patients". She stated this meant documentation of where the patient would be going after acute care. She stated a formal assessment of the hospital's discharge planning process had not been developed. She said a review of discharge plans to ensure that they were responsive to discharge needs was not being done.	A 843	4. Evaluation of coordinated discharge planning process through assessment of: correlation of assessed discharge needs with final discharge plan and documentation of communication between disciplines. - See Attachment F (PI Form) Director of Quality/designee to monitor for compliance.	Dec. 31, 2007

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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November 27, 2007

Patrick Hermanson
Portneuf Medical Center
651 Memorial Drive
Pocatello, Idaho 83201

RE: Portneuf Medical Center, provider #130028

Dear Mr. Hermanson:

This is to advise you of the findings of the State Licensure Complaint Investigation Survey of Portneuf Medical Center, which was concluded on November 2, 2007.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **December 10, 2007**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130028	A. BUILDING _____ B. WING _____	C 11/02/2007

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation survey of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Patricia O'Hara, RN, HFS Acronyms used in the survey report include: ADL = Activity of Daily Living CM = Case Manager DME = Durable Medical Equipment EMR = Electronic Medical Record SNF = Skilled Nursing Facility SWS = Social Work Services VA = Veterans Administration	B 000	RECEIVED DEC 10 2007 FACILITY STANDARDS	
BB118	16.03.14.200.04 Discharge Planninig 04. Discharge Planning. Administration shall provide a procedure to screen each patient for discharge planning needs. If discharge planning is necessary, a qualified person shall be designated responsible for such planning. The hospital shall have a transfer agreement with a Medicare and/or Medicaid skilled nursing home. If there is a common governing board for a hospital and a skilled nursing home, a policy statement concerning transfers will be sufficient. (10-14-88) This Rule is not met as evidenced by: Based on review of clinical records and hospital policies and staff interview, it was determined the hospital's administration failed to provide a procedure to screen each patient for discharge planning needs. The hospital also failed to provide discharge planning services for 7 of 7 sampled patients (#s 1, 2, 3, 4, 5, 6, and 8) whose records were reviewed for discharge	BB118	Refer to Plan of Correction for: - A 799 - A 800 - A 806 - A 818	Dec.31, 2007

Bureau of Facility Standards

Patricia M. Hemmen — TITLE CEO — (X6) DATE 12-6-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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BB118	Continued From page 1 planning. Refer to A806 and A818 as they relate to the lack of discharge planning evaluations and discharge plans.	BB118		